Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 ● Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: VISTA HOSPITAL OF DALLAS 4301 VISTA ROAD PASADENA TX 77504	MFDR Tracking #: M4-09-B583-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: CHUBB INDEMNITY CO. REP. BOX #: 17	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "…With Regard to the charges at issue in this dispute, there is no evidence presented by the Carrier that the prices billed were not Provider's usual and customary charges (which the Provider must bill under Division rules) or that the final price was not fair and reasonable. Therefore, the Carrier is required to reimburse Vista Hospital of Dallas $5,428.78 pursuant to the Outpatient Fee Guideline, which will result in a fair and reasonable reimbursement for the services provided to the injured worker… The Carrier made a partial payment of $4,660.95. Therefore, the Carrier is required to reimburse Provider in the additional amount of $767.83, plus any and all applicable interest…"

Principle Documentation:

1. DWC 60 package
2. Hospital or Medical Bill
3. EOBs
4. Medical Reports
5. Total Amount Sought $767.83

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "…This date of service was paid based upon the medicare [sic] reimbursement plus the percentage increase specific to this case. Therefore, the Provider has been correctly paid and is owed no additional reimbursement…"

Principle Documentation:

1. DWC 60 package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Services in Dispute	Calculation	Amount in Dispute	Amount Due
08/27/2008	Outpatient Hospital Services	$6333.57 (APC) +$0.00 (Outlier Amount) = $6333.57 (OPPS) x 200% = $12,667.14 (MAR) - $4,660.95 (Total paid by Respondent) = $8,006.19	$767.83	$767.83
			Total Due:	$767.83

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule §134.403, titled ***Hospital Facility Fee Guideline – Outpatient,*** effective for medical services provided in an outpatient acute care hospital on or after March 1, 2008, set out the reimbursement guidelines for Hospital outpatient services.

This dispute was filed in the form and manner as prescribed by 28 TAC §133.307 and is eligible for Medical Dispute Resolution under 28 TAC §133.305 (a)(4).

1. According to the Table of Disputed Services all CPT Codes/Revenue Codes are being disputed with the exception of CPT Codes 87070 and 82948 billed under Revenue Code 300 and CPT Code 94762 billed under Revenue Code 460. CPT Codes 87070 and 82948 are Status A codes and paid under a Fee Schedule or with a prospectively pre-determined rate. CPT Code 94762 is a Status N code. Status N codes are services or procedures included in the APC rate, but not paid separately. The amount calculated and ordered does not reflect the payment amount for these particular codes.

2. The services listed in Part IV of this decision were denied or reduced by the Respondent with the following reasons: The Requestor submitted an Explanation of benefits from the CHUBB Group that did not contain ANSI codes; the listed date of audit is 11/13/08:
   - Reason: Workers' Compensation State Fee;
   - Reason: Included in another billed pro, Procedure/Service is not paid;
   - Reason: Procedure/Service is not paid;
   - Reason: Workers' Compensation State Fe, Not paid under OPPS: billed in; and
   - Reason: Procedure/Service is not paid, Not paid under OPPS: Services,

   The Respondent submitted an Explanation of Benefits from Corvel with a listed audit date of 11/11/08:
   - B15 – Procedure/Service is not paid separately;
   - RB – No paid under OPPS; billed incorrectly;
   - R36 – Included in another billed procedure;
   - RN – Not paid under OPPS: services included in APC rate; and
   - W1 – Workers' Compensation State Fee Schedule Adj.

3. Rule 134.403 (e) states in pertinent part, "Regardless of billed amount, reimbursement shall be:

   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code 413.011; or

   (2) if no contracted fee schedule exists that complies with Labor Code 413.011, the maximum allowable reimbursement (MAR) amount under subsection (f), including any applicable outlier payment amounts and reimbursement for implantables;"

4. Pursuant to Rule §134.403(f), "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register.* The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 200 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.

5. Under the Medicare Outpatient Prospective Payment System (OPPS), all services paid under OPPS are classified into groups called Ambulatory Payment Classifications or APCs. Services in each APC are similar clinically and in terms of the resources they require. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC for an encounter. Within each APC, payment for ancillary and supportive items and services is packaged into payment for the primary independent service. Separate payments are not made for a packaged service, which is considered an integral part of another service that is paid under OPPS. An OPPS payment status indicator is assigned to every HCPCS code. Status codes are proposed and finalized by Medicare periodically. The status indicator for each HCPCS codes is shown in OPPS Addendum B which is publicly available through the Centers for Medicare and Medicaid services. A full list of status indicators and their definitions is published in Addendum D1 of the OPPS proposed and final rules each year which is also publicly available through the Centers for Medicare and Medicaid services.

6. Upon review of the documentation submitted by the Requestor and Respondent, the Division finds that:

   (1) No contract exists;

   (2) MAR can be established for these services; and

   (3) Separate reimbursement for implantables was *NOT* requested by the requestor.

7. HCPCS Code J3490 was billed under Revenue Code 250; A4649 was billed under Revenue Code 270 and A4649 was billed under Revenue Code 272. These HCPCS codes have a payment status of "N." Status "N" is used for services or procedures included in the APC rate, but not paid separately as these are packaged items. As a result, the amount ordered is $0.00.

8. CPT Code 29880 was billed under Revenue Code 360. This CPT code has a payment status code of T. Status T codes are considered to be outpatient significant procedures subject to multiple procedure discounting. The highest paying Status T APC is paid at 100%; all others are paid at 50%. The maximum allowable reimbursement for CPT Code 29880 is $12,667.14. As a result, the amount ordered is $767.83.

9. CPT Code 29875 was billed under Revenue Code 360. This CPT Code has a payment status code of T. Status T codes are considered to be outpatient significant procedures subject to multiple procedure discounting. The highest paying Status T APC is paid at 100%; all others are paid at 50%. This code also has an error code of 040. Error code 040 is defined as, "This comprehensive procedure includes one or more components which require a modifier. Review of the UB-04 shows the Requestor did not attach a modifier; as a result, the amount ordered is $0.00

10. CPT Code 99144 billed under Revenue Code 370 has a Status indicator code of N. Status N codes are services or procedures included in the APC rate, but not paid separately. As a result, the amount ordered is $0.00.

11. CPT Code 99205 was billed under Revenue Code 710. This CPT Code has a payment status code of V. Status V codes are defined as "Clinic or Emergency Department visit; may include ER physician or personal physicians." This code also has an error code of 021. Error code 021 is defined as "A medical visit was billed on the same days as a APC procedure, without using Modifier 25. Review of the UB-04 shows the Requestor did not attach a modifier; as a result, reimbursement is $0.00.

12. CPT Code 99234 was billed under Revenue Code 760. This CPT Code has a payment status code of B. Status B codes are defined as "Not recognized by OPPS on Bill Type 12X, 13X or 14X; an alternate CPT/HCPCS code may be available." This code also has an error code of 062. Error code 062 is defined as "While this code is not recognized by OPPS, alternate codes may be. Consider rebilling the claim." As a result, the amount ordered is $0.00.

Based upon the documentation submitted by the parties and in accordance with Texas Labor Code Sec. 413.031 (c), the Division concludes that the requestor is or is not due additional payment. As a result, the amount ordered is $767.83.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. 413.011(a-d), 413.031 and 413.0311
28 TAC Rule §134.403
28 TAC Rule §133.305
28 TAC Rule §133.307

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031 and §413.019 (if applicable), the Division has determined that the requestor is entitled to $767.83 reimbursement for the services involved in this dispute.

Authorized Signature	Auditor III Medical Fee Dispute Resolution	April 26, 2010 Date

PART VIII: : YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.